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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
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EXAMINER	
HARLE, JENNIFER I	

ART UNIT	PAPER NUMBER
3627	

DATE MAILED: 11/26/2003

Please find below and/or attached an Office communication concerning this application or proceeding.

Office Action Summary	Application No.	Applicant(s)	
	10/088,795	MARTIN ET AL.	
	Examiner	Art Unit	
	Jennifer I. Harle	3627	

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If the period for reply specified above is less than thirty (30) days, a reply within the statutory minimum of thirty (30) days will be considered timely.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133).
- Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

1)☒ Responsive to communication(s) filed on *08/13/03* .

2a)☒ This action is **FINAL**. 2b)☐ This action is non-final.

3)☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

4)☒ Claim(s) *1-6,8-15 and 17-21* is/are pending in the application.

4a) Of the above claim(s) _____ is/are withdrawn from consideration.

5)☐ Claim(s) _____ is/are allowed.

6)☒ Claim(s) *1-6,8-15 and 17-21* is/are rejected.

7)☐ Claim(s) _____ is/are objected to.

8)☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

9)☐ The specification is objected to by the Examiner.

10)☐ The drawing(s) filed on _____ is/are: a)☐ accepted or b)☐ objected to by the Examiner.

Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).

11)☐ The proposed drawing correction filed on _____ is: a)☐ approved b)☐ disapproved by the Examiner.

If approved, corrected drawings are required in reply to this Office action.

12)☐ The oath or declaration is objected to by the Examiner.

Priority under 35 U.S.C. §§ 119 and 120

13)☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).

a)☐ All b)☐ Some * c)☐ None of:

1.☐ Certified copies of the priority documents have been received.

2.☐ Certified copies of the priority documents have been received in Application No. _____ .

3.☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

* See the attached detailed Office action for a list of the certified copies not received.

14)☐ Acknowledgment is made of a claim for domestic priority under 35 U.S.C. § 119(e) (to a provisional application).

a) ☐ The translation of the foreign language provisional application has been received.

15)☐ Acknowledgment is made of a claim for domestic priority under 35 U.S.C. §§ 120 and/or 121.

Attachment(s)

1) ☒ Notice of References Cited (PTO-892)
2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
3) ☐ Information Disclosure Statement(s) (PTO-1449) Paper No(s) _____ .
4) ☐ Interview Summary (PTO-413) Paper No(s). _____ .
5) ☐ Notice of Informal Patent Application (PTO-152)
6) ☐ Other: .

DETAILED ACTION

Claims 1-6, 8-15, and 17-21 were pending. Claims 1, 13 and 18-21 were amended by Applicant's Response. The Office Action, Paper No. 4, is incorporated by reference.

Response to Arguments

A. Explanation of Invention

Applicant argues that the examiner is "fixed" on the incorrect assumption that the present invention is an insurance system or plan and/or that all systems for the payment of fees to a clearinghouse for later payment to service provider somehow must be an insurance system or plan. Applicant then states that "the system of the present invention can be considered as part of the broad category of "health benefits" and attempts to distinguish the claimed invention as an alternative to an insurance system.

Applicant provides promotional literature and a Declaration under 37 CFR 1.132 of Mike Musgrove. The examiner notes the promotional literature and while interesting, does not find that it has any bearing upon whether or not the prior art cited reads upon the claims as written. The examiner does note that the promotional literature states that the product is not an insurance plan. However, the product can be encompassed within the claims as can the art cited.

Applicant additionally provides a Declaration under 37 C.F.R. 1.132 of Mike Musgrove. Mr. Musgrove states that Primexis is a new and innovate product and that the product is a non-insurance product. Applicant argues that this Declaration of Mr. Musgrove specifically declares that the system of the present invention is not an insurance product. However, Mr. Musgrove only speaks to the Premexis product and never once references the Specification or the Claims.

While Primexis may be an embodiment encompassed within the claims, the Declaration about its features is not relevant as it does not mention the prior art of record, why it would not read upon the claims or fall within the scope of the claims. He never once defines an insurance product, and only makes a sweeping comment that compared to conventional insurance products, such as HMOs and PPOs, this is a breakthrough. This statement appears to be a contradiction, if compared to convention insurance products it is a breakthrough, is it not then an insurance product.

The claims were not rejected under obviousness but rather under 102 and anticipation.

Mr. Musgrove states that the product can be considered as part of the broad category of "health benefits" but that not all "health benefits" are insurance products. Yet, he fails to state why HMOs and/or PPOs providing "health benfits" would not be encompassed within the definitions in the Specification and claims. He continues on to talk about Primexis as a system for the payment of medical services to doctors and that it was developed to be an alterative to medical insurance as medical insurance payments have been decreasing over the years. He also describes the features of Primexis. One feature that he describes as setting Primexis apart from insurance plans is that the clearinghouse does not have an obligation to reimburse patients. Another feature he states that sets Premexis apart is that the doctor subscribes directly with the clearinghouse to receive payments for medical services rendered and is not in a subrogation position relative to the patient but is in a direct payment for service position relative to the clearinghouse, and therefore is not in an insurance relationship with the patient or the clearinghouse. A further feature is the Primexis does not set the doctor's fees, as is typical in an insurance plan, but allows the doctors to determine their own rates and levels of service provided

based on historical data, thus allowing the doctors to provide the proper level of service at the proper price without the need for insurance. Yet, no documentation is provided with this Declaration to substantiate any of these claims.

Thus, although the Affidavit appears to be an attempt to differentiate Applicant's invention from the prior art and to demonstrate some form of need for the product, it fails to establish any nexus to the claims or the specification and merely states that this is not a form of an insurance product, by illustrating Applicant's preferred embodiment. The Affidavit provides no definition of an insurance product, how an HMO or PPO would fail to meet that specific definition and even if it did fail to meet that definition, how it would fail to meet the claim limitations as set forth by the examiner. All Mr. Musgrave's statements are directed specifically towards Applicant's product, not to the claims, the specification or the prior art. The Declaration draws no correlation between Applicant's product, the claims as written and the prior art as applied. The claims are directed to a system for the payment of service fees to service providers for services rendered to service receivers. Moreover, the system does not preclude insurance products under one of the objects of the invention. See pg. 5, lines 3-7. Thus, the Declaration is not persuasive.

B. Explanation of Amendments to Claims

Applicant states that several new claims have been added to claim the system as a process in a series of steps. However, the examiner does not see any new claims added. Claims have been amended but no new claims have been added.

Applicant asserts that these amendments overcome the 35 USC 101 and 35 USC 102 problems. The examiner respectfully disagrees. These arguments will be commented upon in the preceding sections.

C. Examiner's Definition of Terms

Applicant argues that the examiner has given her definition of terms that Applicant uses in the Specification contrary to the express wording in the Specification. The examiner respectfully disagrees.

1. Clearinghouse

Applicant states that they use of the term "clearinghouse" as the administrator or administration of the system. The applicant then goes on to argue that there are no administrators of a health care plan of any type at the clearing house, and the Specification specifically discloses that the present system is not of the same type as the one cited by the Applicant. Applicant further argues that their "clearinghouse" does not oversee anything more than the financial aspects of the system (that is where the money goes) and the tracking of subscriber service providers and service receivers, i.e. a prepayment administration entity. The examiner respectfully disagrees. Applicant's own specification teaches that the "clearinghouse" has more functions than those stated by Applicant in his arguments. The examiner specifically utilized those functions to define the meaning of the "clearinghouse." See the previous Office Action incorporated by reference.

Applicant argues that their "clearinghouse" is not involved in any way in choosing the doctors or patients (any may subscribe), directing how the doctors provide or the patients receive

services, or deciding on the prices the doctors charge for their services. The examiner notes that this specifically contradicts the Specification at page 7, lines 6-8 and 15-25, where the system can provide for reduced fees for any services rendered by doctors over and above the quantity of services provided for by the system, in initiating the process the clearinghouse and doctors agree on certain terms including type of services to be provided, including quantity and monthly fee and the fee to be paid by the patients each time they visit the doctor. Additionally, the Specification at page 8, lines 5-25 teaches that additional services can be added, monthly fees can be changed, monthly fees paid to doctors can be changed per visit fees can be changed, doctors can be added or removed from the plan, i.e. the clearinghouse can contact recommended doctors to attempt to have the recommended doctors subscribe to the plan, a database of common and preferred rates for various services can be kept to set fee schedules at an appropriate schedule. Additionally, as the central clearinghouse contracts with the professional service providers and they both have to agree on the terms for the provision of services, it is not clear how Applicant has distinguished their "clearinghouse." Clearly through the contracting process the Applicant's clearinghouse is involved in some way with choosing the doctors or patients, directing how the doctors provide or the patients receive services (i.e. limitations on the amount of visits paid for via the contracts and the types of services covered), or deciding on the prices the doctors charge for their services (the database discussed above). Applicant further argues that their "clearinghouse" does not create income from providing services but creates income from providing access to the services of subscriber services providers. The examiner maintains that this is a matter of semantics and even irrelevant. The Specification, pg. 6 lines 16-26, specifically states that the "Patient will pay clearinghouse **a monthly services fee** to obtain a set

of services from this primary care doctor ... Clearinghouse would administer the payments and would pay to the primary care doctor an agreed upon monthly fee, which typically is the monthly services fee less any administrative and other costs incurred by clearinghouse including profits ..." Thus, it certainly appears from Applicant's own wording that some of the income is derived from providing services.

Thus, the examiner has provided ample support for the definition utilized for the term "clearinghouse." As interpreted by the examiner the term "clearinghouse" has been given its ordinary meaning bolstered by Applicant's own specification. Moreover, "[t]he ordinary meaning of a claim term may be determined by reviewing a variety of sources, including the claims themselves, other intrinsic evidence including the written description and the prosecution history, and dictionaries and treatises . . . ." *Teleflex Inc. v. Ficosa North America Corp.*, 299 F.3d 1313, 1325, 63 USPQ2d 1374, 1380 (Fed. Cir. 2002) (citations and quotations omitted).

2. Insurance

Applicant argues that its product is not an insurance product and states that several states including Georgia, Alabama and North Carolina already have found Applicant's system not to be an insurance product. Applicants summary of the invention does not preclude insurance products from the scope of its invention. Specification, pp. 3-4, lines 26-9. Nor do all of the objects, the claims or even the detailed description of the preferred emobidment of the invention preclude the invention from being an insurance product. Specification, pg 5, lines 3-7 and new claims, Specification, Detailed Description of the Preferred Embodiments, pp. 5-10. Applicant defines an insurance product to allow for the payment of a premium in exchange for a future promise to cover an expense. That is exactly what is happening here. The consumer pays a fee,

i.e. a premium, in exchange for a future promise to cover an expense, i.e. certain number of visits and discounts on services. Applicant argues that the medical example is different because the type of coverage bargained for is different, i.e. unknown. The examiner disagrees. The type and quantity of future medical services necessary in either case is unknown but in both cases the coverage or what is bargained for is known. In the medical example, the customer knows what will be covered and what won't, what the co-pays if any are, what the limitations on visits are, what the caps are, etc. The examiner does agree that insurance is a hedge against future medical expenses but does not see how Applicant's invention is not a similar hedge. Granted it might not have as large a hedge but it is still a hedge. The consumer does not have to utilize all the visits.

Applicant next argues that it is a prepayment system for a defined type and quantity of services. As stated previous, insurance premiums are also a prepayment system for a defined type and quantity of services, i.e. HMOs are different from PPOs and have different coverage, limits, co-pays, and benefits. In fact, there are a plethora of different plans with different choices available to the consumer. In each case, whether an HMO or a PPO, the consumer paysan agreed rate for a certain quantity of medical services (drug coverage, well baby visits, ob-gyn visits, psychiatric visits, etc.). Additionally, as set forth in the previous Office Action selection of a primary care physician is required.

Applicant again refers the examiner to Mr. Musgrove's Declaration. However, the previous problems are applicable and there is no nexus between the Declaration and the claims.

D. 35 U.S.C. 101 Rejections

Applicant argues that the first 35 U.S.C. 101 rejection, is interpreted to be an issue of the claim language and structure and not an issue of the invention itself and submits that the amendments cure the deficiencies. The examiner respectfully disagrees.

Claims 1-6, 8-15 and 17-21 were rejection under 35 U.S.C. 101 because the claimed invention is and continues to be directed to non-statutory subject matter because it is not within the technological arts. This deficiency has not been cured by the amendments and the rejection of claims 1-6, 8-15 and 17-21 is maintained and **made final**.

Applicant argues that the second rejection under 35 U.S.C. 101, is improper because there are a plethora of issued patents for systems involving humans and cites three. Claims 1-6, 8-15 and 17-21 were rejection under 35 U.S.C. 101 because it is the examiners position that under the broadest reasonable interpretation of the claim as a whole, they encompass human beings, and thus a 35 U.S.C. 101 rejection was made and is being maintained indicating that the invention id directed to non-statutory subject matter. See MPEP 2105. The examiner has interpreted the language of these claims, such that, the terms service providers/service receivers is not functional language and is thus being given patentable weight. This deficiency has not been cured by the amendments and the rejection of claims 1-6, 8-15 and 17-21 is maintained and **made final**.

The Applicant states that the invention is not merely directed to an abstract idea. The examiner directs Applicant to the previous Office Action as to the rationale behind the abstract idea and lack of technological arts as set forth above.

E. 35 U.S.C. 102 Rejections

Applicant argues once again that his invention is not an insurance product and thus a 102(b) rejection is inappropriate. All of the previous comments and arguments are incorporated herein by reference. The Office Action, Paper No. 4, is also incorporated by reference.

As previously set forth above and incorporated here by reference, there is nothing that precludes the interpretation of the claims as including an insurance product.

Applicant argues that the present system is not an insurance product, but is a prepayment service, and does not provide the same service level as insurance products such as discussed in Kennedy. As previously set forth by the examiner, Kennedy meets Applicant's teaching that an insurance product is a prepayment service. As to Applicant's argument that the levels of service are different, the levels of service are not claimed. In response to applicant's argument that the references fail to show certain features of applicant's invention, it is noted that the features upon which applicant relies (i.e., the same level of service/limited type and quantity or service provided) are not recited in the rejected claim(s). Although the claims are interpreted in light of the specification, limitations from the specification are not read into the claims. See *In re Van Geuns*, 988 F.2d 1181, 26 USPQ2d 1057 (Fed. Cir. 1993). Moreover, where quantity is claimed, it is claimed in such a way that Kennedy teaches it. Applicant is confusing their product with their claims.

Applicant's have amended claim 18's wherein claim so that the primary care doctors set their own fee schedules for the medical services rendered to the patients and are paid by the clearinghouse according to the fee schedule.

A fee schedule is a term of art in the health insurance industry and means the maximum dollar or unit allowance for health services that apply under a specific contract. Margaret E. Lynch, Health Insurance Terminology, Health Insurance Association of America, 1992, pg. 39.

This teaching was set forth in the previous Office Action on pp. 42-43. The doctors set their own fee schedules, it then becomes their choice to participate or not in the plan, just like the Applicant's system. If their fee schedule is too high they will choose not to participate in the plan.

The Office Action, Paper No. 4, is incorporated by reference.

The rejection of claims 1-6, 8-13 and 18-21 under 35 USC 102(b) is maintained and made final.

Conclusion

THIS ACTION IS MADE FINAL. Applicant is reminded of the extension of time policy as set forth in 37 CFR 1.136(a).

A shortened statutory period for reply to this final action is set to expire THREE MONTHS from the mailing date of this action. In the event a first reply is filed within TWO MONTHS of the mailing date of this final action and the advisory action is not mailed until after the end of the THREE-MONTH shortened statutory period, then the shortened statutory period will expire on the date the advisory action is mailed, and any extension fee pursuant to 37 CFR 1.136(a) will be calculated from the mailing date of the advisory action. In no event, however, will the statutory period for reply expire later than SIX MONTHS from the mailing date of this final action.

Any inquiry concerning this communication or earlier communications from the examiner should be directed to Jennifer I. Harle whose telephone number is 703.306.2906. The examiner can normally be reached on Monday through Thursday, 6:30 am to 5:00 pm,.

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Robert Olszewski can be reached on 703.308.5183. The fax phone number for the organization where this application or proceeding is assigned is (703) 872-9306.

Any inquiry of a general nature or relating to the status of this application or proceeding should be directed to the receptionist whose telephone number is 703.308.1113.

Jennifer Ione Harle
October 22, 2003

Richard Chilcot
Supervisory Patent Examiner
Technology Center 3600